Miscellaneous Services

Acute Physical Medicine and Rehabilitation (Acute PM&R)

Inpatient PM&R is limited to Department-contracted facilities. Please see the Department's *Acute PM&R Billing Instructions* for more details.

Cochlear Implant Services for Clients 20 Years of Age and Younger [Refer to WAC 388-531-0200(4) (c)]

The Department does not cover bilateral cochlear implantation. Unilateral cochlear implantation (CPT code 69930) requires EPA (see section I). If a client does not meet the EPA criteria PA is required.

The Department covers replacement parts for cochlear devices through the Department/MPA Hearing Aids and Services Program ***only***. The Department pays only those vendors with a current core provider agreement that supply replacement parts for cochlear implants and bone-anchored hearing aids (BAHA).

Note: The Department does not pay for new cochlear implantation for clients 21 years of age and older. The Department considers requests for removal or repair of previously implanted cochlear implants for clients 21 years of age and older when medically necessary. Prior authorization is required.

CPT Codes	Description	Notes
69930	Cochlear device implantation, with or without mastoidectomy	There are no corresponding removal codes specific to cochlear devices.
69715	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy	

Collagen Implants

The Department pays for CPT code 51715 and HCPCS codes L8603 and L8606 only when the diagnosis code is 599.82 (Intrinsic sphincter deficiency). See Section K for limitations.

DDD Physical

The Department covers one physical every 12 months for clients with disabilities. Use HCPCS code T1023 with modifier HI and an ICD-9-CM diagnosis code from the range V79.3-V79.9 to bill for an annual exam.

Diabetes Education (HCPCS Code G0108 and G0109) [WAC 388-550-6300]

Please refer to the current Department/MPA Diabetes Education Billing Instructions at: http://hrsa.dshs.wa.gov/download/Billing_Instructions_Webpages/Diabetes_Education_BI.html.

Genetic Counseling and Genetic Testing

The Department covers genetic counseling for all FFS adults and children when performed by a physician.

To bill for genetic counseling, use diagnosis code V26.33 genetic counseling and the appropriate E&M code.

Certain genetic testing procedure codes need PA. Physicians must obtain PA if required for certain genetic tests and must give both the PA number and the appropriate genetic testing modifier to the laboratory or when the laboratory bills so they can bill correctly.

> **Note:** DOH approved genetic counselors provide counseling for pregnant women (fee for service and healthy option clients) up to the end of the month containing the 60th day after the pregnancy ends. This service does not require authorization. To locate the nearest DOH-approved genetic counselor call DOH at 1-253-395-6742.

Group Clinical Visits for Clients with Diabetes or Asthma

Overview of the Program

The intent of the Diabetes and Asthma Group Clinical Visits program is to provide clinical services and educational counseling to Department clients who have been diagnosed with diabetes or asthma. These visits are limited to groups of two or more clients and are payable only to physicians or advanced registered nurse practitioners (ARNPs). However, participation from other professional staff, including physician assistants, physical therapists, nurses, and nutritionists, is encouraged.

Program Requirements

- Prior to a group clinical visit, the provider must perform an assessment of individual client medical information and document the proposed treatment plan for each client.

- The group clinical visit must be led by a physician or ARNP, but may include other staff as well.

- The group clinical visit must last at least one hour and include:

  - ✓ A group discussion on clinical issues to promote long-term disease control and self-management. This discussion should include at least one of the following topics:

    - ➢ Prevention of exacerbation or complications;
    - ➢ Proper use of medications and other therapeutic techniques (spacers, peak flow meter use; glucose measurement, foot care, eye exams, etc.); or
    - ➢ Living with a chronic illness;

  - ✓ A question and answer period;
  - ✓ The collection of prevention-based care data needed to monitor chronic illness (e.g., weight and blood pressure); and
  - ✓ Short (approximately 5-10 minutes per client) one-on-one visits to gather needed data and establish an individual management plan with the client.

- The following must be documented in the medical record:

  - ✓ Individual management plan, including self-management capacity;
  - ✓ Data collected, including physical exam and lab findings;
  - ✓ Patient participation; and
  - ✓ Beginning and ending time of the visit.

Billing and Reimbursement

Providers must use the following CPT code when billing for diabetes or asthma group counseling visits, subject to the limitations in the chart below. Providers must bill visits in increments of one-hour units (one hour = one unit). Multiple units may be billed on the same day.

CPT Code	Restricted to Diagnoses	Visit Limitations
99078	Diabetes: 250.00-250.93 Asthma: 493.00-493.92	Limited to four (4) one-hour units per calendar year, per client, per condition

Note: The Department pays only for the time that a client spends in the group clinical visit.

Other Limitations

The Department does not reimburse a diabetes or asthma group clinical visit in conjunction with an office visit or other outpatient evaluation and management (E&M) codes for the same client, same provider, and same condition on the same day.

A diabetes group clinical visit may be billed on the same day as a Department of Health (DOH) - approved diabetes education core module as long as the times documented in the medical record indicate two separate sessions.

HIV/AIDS Counseling

The Department covers two sessions of risk factor reduction counseling (CPT code 99401) counseling per client, each time tested. **[Refer to WAC 388-531-0600]** Use ICD-9-CM diagnosis code V65.44 when billing CPT code 99401 for HIV/AIDS counseling. The Department does not pay for HIV/AIDS counseling when billed with an E&M service unless the client is being seen on the same day for a medical problem and the E&M service is billed with a separately identifiable diagnosis code and with modifier 25. Please see the Department's *HIV/AIDS Case Management, Title XIX (Medicaid) Billing Instructions* for additional information on HIV/AIDS case management billing.

Hyperbaric Oxygen Therapy (CPT 99183)

Hyperbaric oxygen therapy requires EPA- see section I. If the client does not meet the EPA criteria, PA is required.

Irrigation of Venous Access Pump

CPT code 96523 may be billed as a stand-alone procedure. However, if billed by the same provider/clinic on the same day as an office visit, you must use modifier 25 to report a separately identifiable medical service. If you do not use modifier 25, the Department will deny the E&M code.

Needle Electromyography (EMGs)

The Department has adopted Medicare-established limits for billing needle EMGs (CPT codes 95860 – 95870) as follows:

CPT Code	Brief Description	Limits
95860 95861 95863 95864	Needle EMG; one extremity with or without related paraspinal areas **two extremities…** **three extremities…** **four extremities…**	• Extremity muscles innervated by three nerves or four spinal levels must be evaluated with a minimum of five muscles studied.
95865	Muscle test, larynx	• Limited to one unit per day.
95866	Muscle test, hemidiaphragm	• Limited to one unit per day.
95869	Needle EMG; thoracic paraspinal muscles	• Limited to one unit per day. • For this to pay with extremity codes 95860-95864, test must be for T3-T11 areas only; T1 or T2 alone are not separately payable.
95870	Needle EMG; other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters	• Limited to one unit **per extremity**, and one unit for cervical or lumbar paraspinal muscle, regardless of number of levels tested (maximum of 5 units). • Not payable with extremity codes (CPT codes 95860-95864).

Nerve Conduction Study (NCS)

CPT Code	Brief Description	Limits
95900, 95903, and 95904	Nerve Conduction Study	Each nerve constitutes one unit of service

Osseointegrated Implants (BAHA) for Clients 20 Years of Age and Younger

Insertion or replacement of osseointegrated implants (BAHA) (CPT codes 69714-69718; HCPCS L8693) requires prior authorization (PA) (refer to Section I - Prior Authorization).

The procedure can be performed in an inpatient hospital setting or outpatient hospital setting.

The Department covers replacement parts for BAHA through the Department's Hearing Hardware for Clients 20 Years of Age and Younger Program ***only***. The Department pays only those vendors with a current core provider agreement that supply replacement parts for cochlear implants and BAHA.

Note: The Department does not pay for new BAHA for clients 21 years of age and older. The Department considers requests for removal or repair of previously implanted BAHA for clients 21 years of age and older when medically necessary. PA is required.

CPT Codes	Description	Notes
69710	Implantation or replacement of electromagnetic bone conduction hearing device in temporal bone	Replacement procedure includes removal of the old device
69711	Removal or repair of electromagnetic bone conduction hearing device in temporal bone	
69714	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy	
69715	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy	
69717	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy	

Out-of-State Hospital Admissions (does not include border hospitals)

The Department pays for emergency care at an out-of-state hospital, not including hospitals in bordering cities, only for Medicaid and SCHIP clients on an eligible program. See WAC 388-501-0175 for recognized bordering cities.

The Department requires PA for elective, non-emergency care and only approves these services when:

- The client is on an eligible program (e.g., the Categorically Needy Program); and
- The service is medically necessary and is unavailable in the State of Washington.

Providers requesting elective, out-of-state care must send a completed Out-of-State Medical Services Request Form, DSHS 13-787, with additional required documentation attached, to the Department Medical Request Coordinator (See *Important Contacts*).

Providers must obtain prior authorization from the appropriate MHD designee for **out-of-state psychiatric hospital admissions** for all Medicaid clients. Neither the Department nor the MHD designee pays for inpatient services for non-Medicaid clients if those services are provided outside of State of Washington. An exception is clients who are qualified for the General Assistance – Unemployable (GAU) program. For these clients, the Department and the MHD designee pays for inpatient psychiatric services provided in bordering cities and critical border hospitals. All claims for admissions to **out-of-state hospitals** are paid as **voluntary** legal status as the Involuntary Treatment Act applies only within the borders of Washington State.

Outpatient Cardiac Rehabilitation

The Department covers outpatient cardiac rehabilitation in a hospital outpatient department for eligible clients who:

- Are referred by a physician;
- Have coronary artery disease (CAD);
- Do not have specific contraindications to exercise training; and
- Have:

  - ✓ A recent documented history of acute myocardial infarction (MI) within the preceding 12 months;
  - ✓ Had coronary angioplasty (coronary artery bypass grafting [CABG];
  - ✓ Percutaneous transluminal coronary angioplasty [PTCA]); and/or
  - ✓ Stable angina.

Bill physician services with procedure code 93798 or G0422 that includes continuous ECG monitoring (per session) with one of the following diagnosis codes:

- 410.00-410.92 (Acute myocardial infarction);
- 413.0-413.9 (Angina pectoris);
- V45.81 (Aortocoronary bypass status);
- V45.82 (Percutaneous transluminal coronary angioplasty status); or

> **Note:** Cardiac rehabilitation does not require PA, and it is only approved for the above diagnoses.

The Department **does not** cover procedure code 93797 or G0423.

The outpatient cardiac rehab program hospital facility must have all of the following:

- A physician on the premise at all times, and each client is under a physician's care;
- Cardiopulmonary emergency equipment and therapeutic life-saving equipment available for immediate use;
- An area set aside for the program's exclusive use while it is in session;
- Personnel who are:
  - ✓ Trained to conduct the program safely and effectively;
  - ✓ Qualified in both basic and advanced life-support techniques and exercise therapy for coronary disease; and
  - ✓ Under the direct supervision of a physician;
- Non-physician personnel that are employees of the hospital;
- Stress testing:
  - ✓ To evaluate a patient's suitability to participate in the program;
  - ✓ To evaluate chest pain;
  - ✓ To develop exercise prescriptions; and
  - ✓ For pre and postoperative evaluation of coronary artery bypass clients;
- Psychological testing or counseling provided if a client:
  - ✓ Exhibits symptoms such as excessive fear or anxiety associated with cardiac disease; or
  - ✓ Has a diagnosed mental, psychoneurotic, or personality disorder; and
- Continuous cardiac monitoring during exercise or ECG rhythm strip used to evaluate a client's exercise prescription.

The Department covers up to 24 sessions (usually 3 sessions a week for 4-6 weeks) of cardiac rehab exercise sessions (phase II) per event. The clients must have continuous ECG monitoring. The Department covers continued participation in cardiac rehab exercise programs beyond 24 sessions only on a case-by case basis with preauthorization.

Physical Therapy

Please refer to the current Department/MPA Physical Therapy Program Billing Instructions at: http://hrsa.dshs.wa.gov/download/Billing_Instructions_Webpages/Physical_Therapy.html.

TB Treatment Services

The E&M codes 99201-99215 are for office visits only, and must be billed for professional providers such as physicians (or nursing staff under a physician's supervision), Advanced Registered Nurse Practitioners (ARNPs), and Physician Assistants (PAs).

When billing for TB treatment services provided by professional providers in the client's home, Health Departments may also bill CPT codes 99341 and 99347.

TB Treatment Services Performed by Non-Professional Providers

Health Departments billing for TB treatment services provided by **non-professional providers** in either the client's home or in the office must bill using HCPCS code T1020 (personal care services). Do not bill the initial visit with a modifier. Follow-up visits must be billed using T1020 with modifier TS (follow-up services modifier). Use one of the following ICD-9-CM diagnosis codes:

Diagnosis Code	Description
010.00 – 018.96	Tuberculosis infections
795.5	Nonspecific reaction to tuberculin skin test
V01.1	Tuberculosis
V71.2	Observation for suspected tuberculosis
V74.1	Pulmonary tuberculosis

Ultraviolet Phototherapy

The Department does not cover ultraviolet phototherapy (CPT code 96910) when billed with ICD-9-CM diagnosis code 709.01 (vitiligo). The Department considers this a cosmetic procedure.

Ventilator Management

E&M services are not allowed in combination with CPT codes 94002 - 94004, 94660, and 94662 for Ventilator Management on the same day, by the same provider/clinic. However, E&M services may be billed for on the same date of service using modifier 25 to indicate that a significant and separately identifiable service was provided. If modifier 25 is not used, the Department will deny the E&M code.

Vagus Nerve Stimulation (VNS) [Refer to WAC 388-531-0200(h)]

Vagus nerve stimulation (CPT codes 61885, 61886, and 61888) requires prior authorization (refer to Section H - Prior Authorization).

VNS procedures can be performed in an inpatient hospital or outpatient hospital setting.

Prior authorization is not required for VNS programming (CPT codes 95970, 95974, and 95975) performed by a neurologist.

The Department does not pay for VNS and related procedures for a diagnosis of Depression (CPT 64553-64565, 64590-64595, 95970, 95974, and 95975).